Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

RELEASE OF CONFIDENTIAL INFORMATION
FOR ASSESSMENT CENTER AND ADATSA/ADULT TREATMENT PROVIDERS

1. I, _____, authorize the _____
   CLIENT'S NAME

   Assessment Center and/or DASA Contracted Treatment Provider to disclose or receive information regarding the results of my ADATSA/ADULT evaluation and assessment, related medical/psychological reports, placement recommendations, progress in treatment, and public assistance benefits.

   This information may only be disclosed to the Department of Social and Health Services, Community Service Offices (CSO) and the following contractors providing ADATSA/ADULT assessment, treatment, medical, vocational, shelter, and protective payee services to me:

   a. ADATSA/ADULT Treatment Providers
   b. Other ADATSA/ADULT Assessment Centers
   c. _____
   d. _____
   e. _____
   f. _____

2. This information may only be used for the purposes of:
   a. Assisting me in my treatment planning and case management;
   b. Coordinating my care as a recipient of assessment, referral, treatment, medical, and/or vocational services under the ADATSA, Pregnant and Parenting Women's (PPW), and/or Temporary Assistance for Needy Families (TANF) programs.
   c. Supporting my application for additional state and federal assistance programs; and
   d. Gathering necessary program evaluation, statistical, placement, and reimbursement data on services received.

3. I also authorize the Assessment Center and/or ADATSA/ADULT Treatment Provider to disclose to or receive information regarding the results of my evaluation and assessment, recommendations, and/or progress in treatment from the following agencies or individuals, for the limited purposes stated.

☐ 4. **To coordinate my medical care needs with my chemical dependency treatment:**

INITIALS	NAME	TELEPHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

☐ 5. **For emergencies and messages:**

INITIALS	NAME	TELEPHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

☐ 6. **For compliance with court, probation, or defense needs:**

INITIALS	NAME	TELEPHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

☐ 7. **For (purpose):**

INITIALS	NAME	TELEPHONE NUMBER

I understand that my records are protected under Federal and State Confidentiality Regulations (42 CFR Part 2 and WAC 388-805) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent shall expire 90 days from the date signed. I understand that the payment for my treatment, the delivery of my treatment, eligibility for and enrollment in the service program cannot be denied to me based upon my refusal to sign this release of information.

I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

8. CLIENT SIGNATURE	9. DATE SIGNED	10. EXPIRATION DATE

11. REAUTHORIZATION SIGNATURE	12. DATE SIGNED	13. EXPIRATION DATE